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The Canadian Medical Review

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Vol. VII. APRIL, 1898. No. 4.

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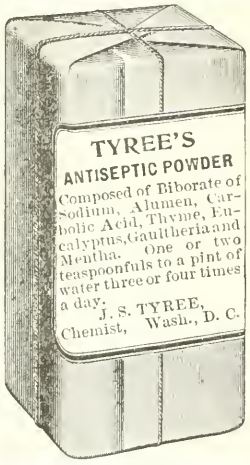
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Vol. VII. TORONTO, APRIL, 1898. No. 4

Original Communications.

A Case of Suprapubic Lithotomy.

By W. J. Gibson, M.A., M.D., C.M., Belleville.

In presenting to the Association the history of a case of suprapubic lithotomy I do so because of the fact that the attention of the profession has been directed to the operation as safer and more easily performed, especially in case of very large stones or in small encysted stones, than lateral lithotomy.

The patient whose case I am about to present was a man over seventy years of age. He first came under my notice ten years ago when suffering from an attack of acute retention of urine believed to have been occasioned by exposure to cold. On attempting to pass a catheter, I found that I had to deal with a spasmodic stricture in the membranous portion of the urethra. With a little patience and persistent effort I succeeded in introducing a No. 9 silver catheter and evacuated the contents of the bladder (about three pints in all). I provided him with a soft rubber catheter with directions to use it only if he found difficulty in emptying the bladder. In a few days time he again presented himself and asked me to procure for him a silver

catheter, as he believed he could manage it better than a soft rubber, thought he had been able to introduce the soft rubber after a good deal of effort.

I accordingly gave him a silver catheter, after instructing him how to use it. I did not see him again until last October as he had moved to an adjoining town. When he again presented himself last fall I was forcibly struck by the change in his appearance. He had grown thin and pale, and his face showed traces of continued suffering. He informed me that ever since he had last consulted me, he had been compelled to use the catheter, at first not more than four or five times in twenty-four hours, continuing at about the same rate for several years, and occasionally having to use it more often, until two years ago, when it became necessary for him to use it several times a day, the frequency of its use gradually increasing, so that in the last six months before presenting himself, he had been obliged to use it every hour or two day and night.

Suspecting their might be a stone in the bladder I admitted him to the hospital for examination. On the following day I passed a sound and at once discovered a large stone embedded in the posterior wall of the bladder and absolutely immovable. The stone was encysted, and, as far as I could make out, was something over an inch in diameter. Dr. Clinton kindly saw the case with me and operation was determined upon. The nature of the case and its surgical treatment was fully explained to the patient, after which he consented to submit to operation. He requested to be allowed to return home for a few days to look after some business affairs, promising to return in a short time. Returning on the 1st December, he was again admitted to the hospital and prepared for operation by four days' rest in bed, together with frequent irrigation of the bladder with warm boric acid solutions. (The morning before the operation he was given a warm bath and the bowels thoroughly evacuated.) He suffered pain both during and especially after urinating, but at no time had he ever passed any blood. The urine had a specific gravity of 1025, neutral in reaction, no albumen and no sugar. There was an abundant sediment of mucus and phosphates. The prostate was slightly enlarged on its rectal aspect. The capacity of the bladder was ascertained by first drawing off all the urine and then filling with boric solution, when it was found that as soon as two and a half ounces were thrown in the pain became severe; this fact explained the frequency of urination. Being convinced that the stone was encysted and having ascertained that the bladder would not hold more than two and a half ounces of water without an anæsthetic, I determined to adopt the high operation.

The patient being placed upon the operating table the pubes were shaved and the field of operation thoroughly cleansed, Dr. McColl administered the anæsthetic, and Dr. Clinton assisted me in the operation. The usual pear-shaped rubber bag was inserted into the rectum and slowly distended with eleven ounces of warm water. I adopted this procedure for the reason that, having distended the rectum and thus raised the fundus of the bladder, I would be enabled more readily to decide how much water would be required to safely distend the bladder as much as required.

By percussing over the bladder as it was being slowly filled with warm boric solution, I found that when eight ounces were injected the bladder had become quite prominent against the anterior abdominal wall to a distance of over three inches above the pubes. A rubber tube was tied around the penis to retain the water. An incision three inches in length was made in the mesial line through the abdominal wall down to the prevesical fat, which was carefully divided without tearing or undue disturbance, and the wall of the bladder reached. Having provided two full curved needles armed with sterilized silk, a suture was passed through the wall of the bladder on either side of the incision and given to my assistant. At this stage the patient was seized with vomiting and the peritoneum was observed to bulge down slightly into the wound. Dr. Clinton kept it out of harm's way with his finger and I at once opened the bladder with a quick thrust of the knife; the incision was extended so as to readily admit two fingers.

At this stage the hæmorrhage was free. The fingers were quickly passed into the bladder and the stone located. Some difficulty was experienced in dislodging it from its imbedded position, but with the aid of the index finger and seizing the stone with the lithotomy forceps this was soon accomplished and the stone extracted.

Hæmorrhage became still more free but soon subsided as the rectal bag was emptied. The bladder was thoroughly irrigated with hot boric solution. It was not considered advisable to attempt to close the wound in the bladder. Two rubber tubes eighteen inches in length and carefully prepared were selected, stitched together at intervals with silk, and several inches dropped into the bladder. The abdominal wound was partially closed by deep sutures, leaving the tubes in the lower angle of the wound. Iodoform gauze was then packed firmly in the wound around the tubes and the patient conveyed to bed. An additional piece of tubing was attached to each of these so as to facilitate drainage over the side of the bed into a vessel. This arrangement of tubing acted so admirably, that the dressing was not even soiled, and it was found possible to irrigate the bladder

without disturbing the dressing. On the morning of the third day after the operation I thought it advisable to remove the tubes, but after explaining to the patient what I proposed to do, he begged to have the tubes left for some time longer, as he was so comfortable ; they were accordingly left in for five days, when they were removed, the wound plugged with iodoform gauze and a soft rubber catheter introduced into the bladder, per urethram, and tied *in situ* by winding a gauze bandage around the penis and stitching the catheter securely to the bandage. The urethra had become so tolerant of instruments from long-continued use, that I had no hesitation in leaving the catheter fastened in, in the above manner. The catheter was removed once a day and thoroughly cleansed, after which it was reintroduced. The presence of the catheter caused no inconvenience and the urine did not pass out through the abdominal wound unless the patient coughed or sneezed. The wound was dressed daily with strips of iodoform gauze passed well down to the bottom. In ten days after the removal of the tubes the wound in the bladder had closed so that there was no escape of urine. A few days after the wound in the bladder had closed the catheter was removed and instructions given that it be passed every four hours, gradually extending the interval until it was necessary to pass it three or four times only in twenty-four hours.

The subsequent progress of the case was uneventful, except that on one occasion just three weeks after operation, the patient requested to be allowed to pass the catheter himself. As he had been accustomed to catheterizing himself I gave permission to use soft rubber catheter. Twenty-four hours afterwards I was informed by telephone that he complained of the urine becoming scanty and asked that something be given him to increase it. Fearing that everything was not all right, I went at once to see him. He informed me that on passing the catheter he was only able to get about a table-spoonful of urine. I at once placed my hand on the abdomen and to my amazement found the bladder very much distended. The depth of the abdominal wound was not yet more than one-third filled up. The catheter was immediately passed, and twenty-two ounces of perfectly normal urine withdrawn to the astonishment of the patient. The condition of the walls of the bladder and the healing of the vesical wound must have been good, otherwise rupture would probably have occurred at least in line of vesical wound.

It is needless to say that precautions were taken to prevent a like recurrence.

The wound was entirely closed in four weeks from time of operation and the patient had gained markedly in health and strength.

The stone, which was phosphatic, weighed seven hundred grains; its largest circumference, five and a half inches; longest diameter, two and a quarter inches.

The patient has since remained well, but is unable to empty the bladder without use of the catheter.

A Case of Graves' Disease, Chorea, Confinement, and Heart Failure.

On March 17th last, I was hastily summoned to Mrs. D., aged 27, at 5 p.m. This lady had been suffering from exophthalmic goitre for about three years. She had formerly had several attacks of chorea during pregnancy, which disappeared after the child was born. On the above date I found her in true labor and the membranes bulging. After making my diagnosis of a breach case, I quickly punctured the membrane and delivered her very rapidly, as there was no time to lose, the pulse being very feeble, delivering her in about eighteen minutes, placenta and all. It was a premature labor, fœtus being between seven and eight months. For her heart I administered nitro-glycerine, brandy, strychnia, digitalis, etc., etc. She got weaker and weaker, dying at half-past two from heart failure. This being an unusual case, pardon me for reporting it.

Yours fraternally, F. H. Kalbfleisch.

Brussels, Ont.

P.S.—*For bites of insects, bee stings, etc.*, apply the cerumen of the ears, which will prevent the swelling and relieve the pain. Try it and be convinced of nature's method. F. H. K.

Society Reports.

Toronto Clinical Society.

THE regular meeting of the society was held on the 10th of March, in St. George's Hall—Dr. Albert A. Macdonald, president, occupied the chair.

There were present the following Fellows :—W. H. B. Aikins, G. S. Ryerson, Allan Baines, J. A. Temple, Edmund E. King, Albert A. Macdonald, Harold Parsons, Herbert Bruce, Elliot Brown, George A. Peters, Bertram Spencer, Alton Garratt, George Bingham, Geoffrey Boyd, Charles Trow.

The minutes of the last meeting were read and adopted.

Syndactylism.—Dr. W. H. B. Aikins presented a case showing the above condition in a man aged 32. The fingers involved were the ring and middle of each hand. The patient had a cousin with a similar deformity.

Dr. George A. Peters presented a patient who had recovered from a compound fracture of the skull with loss of brain substance, with the following history : H. McM., aged eight years, was admitted to the hospital September, 1897, with a history of having been injured through being knocked down by a running horse. He reached the hospital two hours after the accident. On examination, a wound about one-half inch long was found on the right side of the head. Its exact situation was one-half inch from the middle line and one-half inch in front of a line dropped vertically through the external auditory meatus.

Brain substance could be seen oozing from the wound, and pulsation could be detected, a deep depression in the vault of the cranium could be felt subtending the wound. He was conscious, but somewhat somnolent, only rousing on being spoken to sharply or loudly. So far as could be learned, he had never completely lost consciousness. There was complete paralysis of the left arm. The left leg and face retained power of movement.

The diagnosis of compound depressed fracture of the motor area having been made, preparations were made to raise the depressed bone. Guarding the actual wound with a compress soaked in 1.20 ac. carbolic, the whole scalp was shaved and disinfected in the usual way.

Operation.—A cresentic incision, convexity upwards, with a radius of one and a half inches was made so as to include the wound, and the scalp over the whole of the depressed area was raised.

The depression was found to be oval in shape and about one and a half inches in its longest diameter. It was outlined at its margin almost all round by a fissured fracture of the outer table, and from this fissure numerous lines radiated to the centre, which was about one-half inch below the general surface of the skull. There was a small amount of brain substance oozing from the centre of the depression. One of the small triangular pieces of bone was removed, and through the opening thus produced the remainlng fragments were sprung back to their normal level. The fragment first removed was then replaced. The whole wound was then closed by horsehair sutures, a small drain of iodoform gauze being placed in the original wound.

The temperature the next morning rose to 102 1-5 and pulse 124. By night the register was 101 4.5 and 114. Next morning 99 and 94. The subsequent history showed rapid recovery. The wound healed throughout by first intention, but the paralysis of the arm was recovered from very slowly. In about one month, however, all the motions were recovered except extension of the wrist and of thumb and fingers, and these motions are still imperfect, though gaining slowly.

The flexors of the hand are also weak. At present he is able to extend the wrist while the fingers are flexed, or to extend the fingers while the wrist remains flexed; but not to perform both movements at once. The reason for this, apparently, is that the extensora are incapable of successfully overcoming the tonic contractions of the flexors, while the latter are put upon the stretch by extending both the wrist and fingers.

The treatment has consisted in exercise, in voluntary movements, massage, electricity, and the functions are still slowly improving.

It is evident that the portion of the cortex that was destroyed is the area which normally presides over the movements of extension of the wrist and fingers. Horsley and others have shown that while there are certain well defined areas which control certain movements, there are frequently outlying areas which seem to have a subsidiary influence, and may become functionally in the event of destruction of the main centres. In this case it is to be hoped that these subsidiary centres may prove adequate to the performance of the duties thrust upon them by the destruction of the main centre. This patient has youth in his favor, and it is certain that the powers of adaptability are greater in immature than in fully matured brains.

In the meantime, it is important to maintain the nutrition of the nerves and muscles by electricity and massage.

In was Hippocrates who said that no injury of the head was too trivial to be despised or too serious to be despaired of. Injuries to the brain, produced by heavy blows, or falls upon a broad surface, are apt to be productive of a certain amount of bruising and laceration at the seat of injury, together with a greater amount of injury of the cortex at a point diametrically opposite. The explanation is that the blow starts a wave in the semi-fluid brain tissue which breaks violently against the bone opposite, thus producing a bruising and laceration of the cortex at that point with more or less bleeding. Between these two points there may be also traced a track of bruised brain tissue, with minute punctiform hæmorrhages and molecular injury.

On the other hand, injuries to the brain produced by monetary impact of an injuring agent of small area is much less likely to start such a wave, and consequently the injuries produced by sudden, violent blows are usually limited to laceration of the brain substance immediately beneath the part of the skull struck. Thus, non-penetrating or glancing bullet wounds are said to produce the most typical localized cortical lesions. The case just cited is evidently one of localized injury, though we do not know exactly what the nature of the fracturing force was—probably the calk of a horse's shoe.

In regard to prognosis, it must not be forgotten that in injury of this kind there occurs during the process of repair a soldering of the various membranes together. The dura also becomes densely adherent to the skull and thus there is an anchoring of the brain at that part, which in later years may be productive of headache, epileptiform convulsions, or attacks of giddiness on sudden movement.

Dr. Peters presented a second patient, upon whom he had performed a plastic operation to relieve cicatricial fixation of the thumb in flexion. The following was the history of the case :—

The thumb in this case is bound down by a very dense and deep cicatrix, resulting from a deep suppurating wound in the thenar eminence. The short flexor muscles seemed to have sloughed away, and the skin was firmly bound down to the metacarpal bone and the annular ligament. The thumb was drawn inwards so that it lay across the middle of the palm, its tip pointing towards the little finger.

In the operation the cicatrix was divided freely ; also the outer part, of the contracted annular ligament. The anterior and lateral ligaments of the meta-carpo-phalangeal joint was also divided, as well as the remains of the short muscles of the thumb. The long flexor tendon was left undivided, but was dissected out of the cicatrix so that it moved freely.

The wound thus made on the palmar aspect of the thumb was

filled in by dissecting up a flap from the dorsum. This flap was one and a half inches long by three-quarters of an inch wide, and its base was adjacent to the wound in the palm. Care was taken to maintain a good thickness to this flap, so as to insure its vitality. Having been very freely dissected up, the flap was swung from the back to the front of the thumb and stitched into place by horsehair sutures.

The wound on the back was closed in the same way, after very freely undermining its edges in all directions.

The wound was not dressed for six days, and was found to have healed throughout by first intention.

Dr. George A. Bingham showed a boy under his care who had suffered from compound fracture of the superior and inferior maxilla, the base of the skull, with extensive injury of the soft parts.

In a brief description of the case, Dr. Bingham said : I present this more as a curiosity than anything else. Sometime in December this boy was riding a bicycle at a rapid rate along the devil strip with his head down. He came in contact with a butcher cart which was being driven at a rapid rate from the opposite direction, the shaft struck him in the face, crushing his nose and his eye out of sight, passing through the orbit, fracturing the superior maxilla, fracturing the inferior maxilla, fracturing the base of the skull and carrying away a portion of the facial nerve. Dr. R. J. Wilson was called, and at his request I operated on the patient the night of the injury. We first built up a nose, then brought the eye into position, adjusted the orbit and the fractured superior maxilla and hard palate, stitching the soft parts over the hard palate, put the jaw in a splint, and got him in a fair condition. He was vomiting blood freely. Those who saw him thought there was no hope for him, but the subsequent history shows that it is hard to kill a boy.

Occasionally now a small portion of bone comes from the right ear. Owing to the damage done to the facial nerve on the right side, the function of the muscles on that side is gone, and gives the face the appearance it has. The vision of the injured eye now is very good.

Dr. Bingham presented a second patient, with the following history : The patient, a little girl, on January 23rd, 1896, fell while playing, and scratched the skin over the right patella. On the same day it got its feet wet. The wound was not attended to. Five days after Dr. Powell was called in, he noted a flushed area below the patella on the upper end of the tibia, which was very tender. He considered the case one of osteomyelitis and sent her to the hospital under the care of the speaker. On the 29th he (Dr. Bingham) trephined into

the epiphysis of the tibia and found a pus cavity which he scraped out. Healing took place readily. Three days after the patient began to complain of pain in the lower epiphysis of the right humerus. Incision was made and drainage, healing following. The next point attacked was the upper epiphysis of the same bone. Similar operation was done. The next bone attacked was the right tibia at its lower end. Since that time until now (about two years) the patient has returned periodically to the hospital for treatment, undergone operation on some bone and recovered. On one occasion a considerable portion of the right clavicle was removed; at another time the scapula on one side. Few of the long bones had escaped. A considerable portion of two ribs had been removed. The speaker thought that the disease would be sure to reappear. The patient had been put on tonic treatment, and she had the best hygienic care. The last bone affected was one of the ribs on the left side. The wound of this operation was not yet quite healed.

Dr. A. H. Garratt then reported a case, the salient points of which were as follows:

Operation for Penetrating Pistol Wounds of the Abdomen with Perforation of the Stomach. By Alton H. Garratt, M.D.—On January 10th, 1898, at 6 p.m., I was called to York Street to see a case of pistol-shot wounds of the abdomen in a woman thirty years of age. Upon my arrival I found that a quarter of an hour before the patient had been shot in two places with a thirty-two calibre revolver. The pistol had been discharged first from a distance of one foot and the bullet had struck one inch to the right of the median line and three inches above Pupart's ligament. The bullet followed a subcutaneous course, and was afterwards removed near the inferior iliac spine five and a half inches from the point of entrance. The second bullet struck two inches to the right of the median line and three inches above the umbilicus, and had been discharged from a distance of nine feet.

The patient complained of little pain, but was very much excited, having climbed an eight foot fence, wrested the pistol from her husband and would-be murderer and shot a strange man in the thigh who tried to stop her on the street. I made a hurried examination, demonstrating with a probe that one bullet did not produce both wounds, and had the patient sent to St. Michael's Hospital under my care.

I visited my patient again at 8 p.m., and found her lying on her back with knees drawn up and suffering great pain all over the abdomen, although the house surgeon had given an eighth of a grain

of morphine before my arrival. The pulse was 110 and the temperature 100. The abdomen was markedly distended and the face anxious. I decided on laparotomy at once, and ordered one-quarter of a grain more of morphine, while the preparations were being made. It was more than an hour before the patient was prepared and my assistants ready. Dr. J. N. E. Brown administered ether, and during the first stage of anesthesia the patient vomited a pint of blood clots and food. I made my incision four inches in length in the median line above the umbilicus and over the track made by the second bullet through which the probe had passed.

On opening the peritoneum there was a sudden escape of gas, leading Dr. Bingham, who assisted me, to suspect that my knife had wounded a knuckle of intestine. On careful search this was disproven.

The transverse colon was pushed down and the stomach brought up in the wound, and after a short search a perforation of its anterior wall was found, this I close with nine Lembert sutures of fine silk, and continued the search for a wound of exit. After going carefully over the stomach and neighboring organs and finding no other wound, the peritoneum, in easy reach, was cleansed with sponges wrung out of hot sterilized water, and the abdominal wound closed with deep silk worm gut sutures, including all the tissues. A strip of iodoform gauze was passed down the bullet track and brought out between the sutures. Iodoform was dusted over line of wound and iodoform gauze, sterilized gauze and cotton wool completed the dressing, which was held in place with a cotton binder.

The first bullet near the iliac spine was now removed through a small incision and its track lightly packed with a narrow strip of iodoform gauze. I then ordered a search to be made in the vomited matter for the second bullet, but unfortunately it could not be found, and I am still in doubt as to its whereabouts.

Patient recovered from anæsthetic nicely, but complained of little pain all over abdomen.

The next day, January 11th, was given nothing but hot water in 3 doses per mouth, had several attacks of vomiting.

On following day, January 12th, was given an ounce of beef tea per mouth, and the mouth was frequently washed out with ice water, feeding by nutrient enema was commenced and there was no more vomiting. Patient still complained of tenderness over the abdomen.

The dressing was changed and short pieces of gauze inserted in bullet tracks.

From the 12th until the 15th patient was fed on nutrient enema, and steadily improved.

On the 16th feeding by the mouth was commenced, and continued without ill effect.

On the 31st the stitches were removed and the wound was perfectly healed; the bullet-tracks were also healed. Patient was allowed to sit up on February 6th, and was placed on the regular hospital diet. This operation was not undertaken until symptoms indicating perforation of stomach or intestine showed themselves, thereby disproving the assertion of Dr. Parke, of Scranton, Pa., in the *New York Medical Journal* of January 15th, that at such time the operation was always too late.

Dr. George Peters said he was not certain whether or not one should not in these cases, when the history showed pretty clearly that the bullet was fired at close range, explore the wounds at once without waiting for symptoms. If the bullet were fired in a fairly direct way it would be almost sure to go through the abdominal wall. The risk of an exploratory incision was not great.

Dr. King pointed out that it was lucky that the bullet had entered the stomach, instead of lower down, for the contents of that viscus had, no doubt, contributed to the stoppage of the course of the bullet.

Dr. Ryerson rose to say that he had visited many of the leading hospitals of Europe and the United States, and nowhere had he seen better surgery than in Toronto.

Dr. Temple made some remarks on a case of carcinoma uteri. The patient, who was a woman, who had entered the pavilion at the General Hospital under his care. Her age was only twenty-eight, and she was the mother of four children. She was greatly emaciated. On examination, he recognized a cancer on the body of the uterus, and the disease so far advanced that he could not offer the slightest hope by operation. The disease had involved the uterus and had caused hydronephrosis.

Dr. Harold Parsons read the post-mortem report made by Dr. H. B. Anderson, as follows:

Mrs. M., aged 28, general emaciation. Subcutaneous fat scanty. Fundus uteri three inches above the symphisis pubis. The thoracic and abdominal viscera were all examined, but presented nothing special of note, except as follows: Right ureter was three-quarters inch in diameter, being immensely distended with fluid. Right kidney was very pale in color. Weight six and a quarter ounces, and showed marked hydronephrosis. The opening of the ureter into the bladder was involved in the cancerous growth. Left ureter slightly enlarged. Left kidney pale and showed a lesser degree of hydronephrosis. Weight, four ounces. The ulcerating cancerous mass involved the

whole body of the uterus. The cervix was entirely destroyed. The growth involves the whole of the bladder, ulcerating through in the median line, producing a utero-vesical fistula. The orifice of both ureters was involved in the growth. Below it extends into the upper part of the vagina, and behind into the adjacent parts of the rectum. (Bladder was cut through from in front.) Microscopic sections of the growth, which were submitted, show the structure of a glandular cancer, adeno-carcinoma. The cancer evidently originated from the glandular epithelium, but whether those of the cervix or body of the uterus the microscopic examination would not not determine.

Dr. Peters presented two astragali he had removed from a case of double club-foot upon which he had operated. He described the various incisions recommended for the operation.

Dr. G. S. Ryerson and Dr. B. Spencer were appointed a committee to act with committees from other societies in the consideration of the proposed academy of medicine

The Society then adjourned.

The Toronto Medical Society.

THE regular meeting of the Society was held in the Council Chamber, on the 10th of March.

Seven Feet Five Inches.—Dr. J. N. Elliott Brown presented a young man whom he had been treating for a sub-acute attack of rheumatism. His object in presenting the patient was not to call attention to the disease, but rather to the uncommon size of the man, who measured seven feet five inches in height. The patient was well formed and in good health.

Pharyngeal Mycosis.—Dr. Price-Brown read a paper on "Pharyngeal Mycosis."

This was a comparatively rare disease, and when it did occur, it usually affected some part of the fauces. It had various appellations depending on the situation of the fungus, but usually went by the above title.

It is a parasitic disease, composed of small whitish-yellow growths, dense in structure and projected above the mucous membrane upon which it grew. It belongs to the schizomycetes species of fungus, a term applied to a variety of vegetable organisms found in drains, garbage, bogs, etc. These fungi may be found in milk, urine and watery solutions containing organic matter after exposure to the air for any lengthy period. The microscope reveals the thread or rod-

like cells of the leptothrix, imbedded in amorphous granules. If treated with Lugol's solution these bodies assume a bluish tinge, indicating the presence of starch. The cells vary in form according to the anatomical region from which they are removed. When the fungus appears on the surface of the mucous membrane it may be merely superficial, or it may be inserted in a wedge-shaped manner in the parenchyma. In the one, it is simply attached *en masse* to the flattened epithelium and is homogeneously striated in appearance. In the other, where it penetrates deeply into the epithelium, the growth is dense and more granular, and the microscope fails to demonstrate the rod-like cells. When the mycosis enters still deeper into the crypts, the latter become dilated, and filled with a fungous growth and degenerated epithelium. In these cases iodine staining brings out the thread-like bodies colored blue, and also the masses of amorphous matter.

The original source of the fungus is still a matter of question. The leptothrix is frequently found in the mouth and is innocuous; but a condition of impaired health would appear to be all that is required to secure that attachment and growth of the fungus to the pharynx. The peculiar feature is that although the bacteria may be present in large numbers within the oral cavity, they should scarcely find a nidus for development there, and should prefer the faucial region. Possibly the intense muscular activity of the mouth may act as a deterrent to the leptothrix attachment.

Impaired health is supposed to be a predisposing cause. Sex has little if any influence; neither has age.

Dr. Brown said that he had seen only four cases. The first was in a man aged 50; the second in a woman aged 40; the third in a man aged 30; and the fourth in a girl aged 19, whom he presented to the society.

The third was very interesting. Two years ago the patient had suffered from chronic antral disease. Before cure could be accomplished openings had to be made through the alveolus and also the canine fossa. In time there was complete cure and the patient returned home. One year after, the patient came to the city to be treated for a chronic sore throat of which he had complained for several months. On examination no sign of the antral disease was to be seen; but the lateral regions of the pharynx, the tonsils and the base of the tongue were studded with spots of the fungous mycoides. There were possibly one hundred of them. In inquiring for a possible cause it was ascertained that the patient had worked during the winter in polishing cows' horns. Sometimes the odor from the horns

was very strong, and it was after pursuing this occupation for several weeks that his throat commenced to get sore. Could the leptothrix have been existent in the dead matter of the horns, the essayist asked, and the disease have been produced by the inhalation of the leptothrix spores with the powder from the surfaces?

There were few subjective symptoms in this disease. It produces no inflammatory action. It causes a feeling of stiffness rather than soreness. As the plant increases and becomes scattered over a larger area the movements of the pharynx become restrained, the muscles slightly stiffened, and partial dysphagia may result. A slight irritable cough may be produced. The fungus grows most luxuriantly between the crypts of the faucial tonsils; next, on the base of the tongue and lingual tonsil; then on the pharyngeal walls, and last upon the pharyngeal tonsil itself.

Mycosis presents small creamy-white opaque masses projecting above the mucous membrane. They are soft and moist in appearance, but are not easily removed. They will stand a large amount of friction without separating their attachment. Usually a number of the plants are scattered over the area affected, varying in size from a pin's head to a millet seed or larger. There is no inflammatory areola around them. Sometimes they exist for years, presenting few symptoms of a distressing or injurious character.

Upon a hurried or casual examination, it might possibly be mistaken for diphtheria in its first stage. This could only be so when the nests are massed together; but even then the fact that it is non-febrile, undergoes no change, and is intensely chronic, should at once remove all doubt.

From sebaceous accumulations in the crypts of the tonsils it is easily distinguished, by the fact that the former only occur at the mouths of the crypts and are easily pressed out, while the leptothrix growth occurs indiscriminately, independent of the position of the lacunæ, and can barely be removed by any amount of legitimate pressure. There was little or no difficulty in making a diagnosis between this disease and tonsillitis. In pharyngeal mycosis there is nothing dangerous to life, and, as a rule, if left to itself might last through a lifetime. It is quite probable that its long continuance might depress the vital forces and render the subject more susceptible to the influences of other diseases.

The treatment is the eradication of the plant. In a few recorded cases this has been done with facility; but in the majority careful and vigorous treatment has been required, and this has had to be persisted in in many cases for a long time before complete cure can be

obtained. The tincture of iodine, silver nitrate, bichloride of mercury, calomel insufflations have all been used with more or less efficacy. Chromic acid cauterization has its advocates. Curettement has also been recommended. None of these have met with as good results as the use of the galvano-cautery needle. It should be inserted directly into the fungoid deposit, and a number should be done at each sitting. The use of cocaine would be required on each occasion; for, although the cauterization would cause but slight pain, to do it effectually the parts should be kept at rest while the needle is being inserted. Hygienic treatment should always be insisted upon.

Appendicitis.—Dr. J. F. W. Ross reported some cases illustrating different phases of appendicitis.

The first was the case of a man upon whom he had operated, February 8th. The patient had never had inflammation of the bowels before. He was taken ill on the 6th of February, with pain in the abdomen and vomiting. The pain was chiefly localized in the right side. When seen by the essayist, the patient was lying down. There was marked rigidity of the right abdominal muscles, tenderness on pressure between the anterior superior spinous process of the ilium and the notch on the under surface of the liver. He gave the history of a severe chill the day before. The temperature was 100 and the pulse was 100. The face looked anxious. Operation was advised. This was allowed. The abdominal opening was made an inch and a half above Poupart's ligament by the oblique incision. The appendix was adherent to the under surface of the liver. It was gangrenous and filled with pus, but it had not burst. It was carefully removed in the usual way and the wound closed. No drainage tube was inserted. Recovery. The appendix was four and a half inches in length. At a point one and a half inches from the tip the lumen was found to be constricted and the tip was dilated. This dilatation was filled with a grumous offensive pus. The appendix was gangrenous in appearance and the blood-vessels in the mesentery were filled with blood clot, showing complete stagnation of the circulation. There was no foreign body found.

This attack was the first from which the patient had suffered.

Case II. Mr. J. referred to me by Dr. Noble. I saw the patient during his fifth or sixth attack and advised operation. He looked pale, and told me he had never thoroughly recovered from his first attack. The attacks had been coming on at short intervals of a few weeks. The curious feature in this case that the pain was chiefly referred to the left side. I used an incision as in the first case. After considerable difficulty I found the appendix turned downward and

backwards and covered by adhesions and completely bent on itself about its middle. The tip seemed to be in a very atrophic condition as a consequence of some previous attack. It was removed in the usual way. The appendix was two and a half inches long. The site of the original perforation was half an inch from the tip, having been almost completely severed from the rest of the appendix. At a point an inch from the tip the appendix is found completely doubled on itself.

In Case III. the patient had had several attacks. In one he had nearly lost his life. The abdomen was opened on the right side above Poupart's ligament. The omentum was adherent to the cœcum. There were two points at which cheesy matter was found, one on the outer side of the cœcum, the other on the inner and lower side. The points on the outer side when peeled off revealed a perforation of the cœcum; this was closed. The point on the inner side was found, peeled off, and the appendix was found imbedded in a mass of adhesions; in the centre of this cheesy matter was found. It was removed in the ordinary way.

On examining the appendix it was found constricted, although not completely shut off toward the bowel. The end was found distended and filled with grumous pus. The mucous membrane of the cavity was thickened and granular.

Case IV. was referred to me by Dr. Harris. The patient had had several attacks of appendicitis; and when I saw him first he was just recovering from an attack. The case had been diagnosed by one or two of the physicians as a case of tubercular peritonitis, but Dr. Harris claimed that it was appendicitis and advised that the patient wait two or three weeks before opertion, that the sub-acute attack might subside. On examination, the abdomen felt as if there was a small quantity of ascitic fluid present. The intestines were somewhat distended with gas and the wall of the abdomen had a peculiar far-away feeling that is so frequently noticed in cases of tubercular peritonitis. After two or three weeks this condition changed, the abdomen became flat and localized tenderness could be distinctly made out in the right iliac region.

The abdomen was opened to the right of the right rectus muscle by the vertical incision. The omentum and the peritoneum were very much reddened, and the intestine adherent with adhesions that easily broke down. They were evidently recent. The folds of the small intestine were uncoiled and the appendix was peeled out of a bed of adhesions. The appendix was large and long. The bleeding from the intestine was free. There was a constriction in the appendix.

Beyond the constriction there was a dilated portion filled with pus. A foreign body composed of hard fæcal matter was found. The patient made a good recovery.

In the next case, a week before I saw the patient, he had at attack of sudden pain in the right iliac region, which continued. The temperature became elevated, but the pulse was not much affected. There was no vomiting, and on examination tenderness was elicited by pressure midway between the anterior superior spine of the ilium and the ensiform cartilage. No definite mass could be felt under the hand and there was no marked rigidity of the right abdominal muscles. I felt satisfied that there was some serious change that had taken place in connection with the appendix, and that the patient would be safer after an operation than if left alone; I told him he would be safer with his appendix in a bottle, but that he might choose for himself.

Operation was done in the usual way. The appendix was found with a large pinkish-tinted, fat-filled mesentery, freely movable in the abdominal cavity, just under the point of greatest tenderness on pressure. It was difficult to find, owing to the fact that it was very high up and was curled forward in front of the cœcum, on a level with, or a little above, the navel. Patient made a good recovery.

The appendix contained a foreign body—a hardened fæcal mass. After hardening in formaline, I found an area commencing to break down. On examination from the appendiceal side, a small perforation was found leading into the fat.

Owing to the fact that perforation had not taken place into the abdominal cavity the symptoms were not so severe as usual. Had no operation been performed, I am satisfied that in a short time pus would have formed in the mesentery of the appendix, and that it would all probability have perforated into the abdominal cavity and have given rise to the so-called secondary rupture.

Case VI., Mr. V. Patient suffered from several attacks of appendicitis, one of them very severe, in which he nearly lost his life. Did not recover his health; remained pale and anæmic. A thickening could be felt. Opened the abdomen to the right of the right rectus muscle by the vertical incision. After a great deal of searching, found the appendix imbedded in a mass of adhesions upward and outward on a level with the navel. Stripped off the adhesions and finally isolated the appendix. No pus was found. There was evidence of an old perforation, three-eighths of an inch from the tip. The tip remained like a knob almost broken off. The remainder of the appendix did not show any very great change, except that it was very patulous up into the intestine.

These cases illustrate the operation of appendisectomy, when performed in the earliest stage of the disease and in the interval between the intermittent attacks. I have yet to lose the first case after operation performed in the interval between the attacks. Some of these operations have been very difficult, involving a large amount of handling of the intestine, the closure of intestinal perforations, and the clearing out of cheesy material and pus in small quantities. The success of the operation, when done early, has also been very great. In some of the cases I have found it impossible to remove the appendix, and been forced to do nothing but make an incision down over the gangrenous tissues and pack the wound with gauze. These cases have also done well.

But a different tale is to he told regarding those in which medical treatment has been relied on, and the dark wall of the abdominal prieties has remained as a barrier between the eye of the observer and the pathological change within. I am tired of the so-called medicinal treatment of appendicitis. I feel satisfied that with proper precautions five hundred healthy appendices can be removed without a death in the hands of a skilled operator. When this is so, and the four cardinal symptoms that I may again enumerate, namely, sudden pain in the abdomen, vomiting, tenderness on pressure, and rigidity of the right abdominal parities, infallibly point to appendicitis, surely medicinal treatment should be shelved. If I myself had the four cardinal symptoms I should send for a surgeon without delay.

The so-called secondary perforation in my experience means rupture of a gangrenous and distended appendix, or the rupture of an abscess in the mesentery of the appendix, secondary to a perforation into the mesentery. After rupture has taken place, the organ quickly contracts, and it is impossible to say, on examining it, that it has been much distended. Case I. I should have placed beyond surgical aid in a few hours by rupture of his appendix and the discharge of the foul poisonous contents into the peritoneal cavity. Case number V. would in a few days have been placed in a similar position by rupture of pus formed in the mesentery of the appendix, from broken down fat cells into the general peritoneal cavity. Operation cannot be done too quickly.

I saw one case in consultation with Dr. McKeown, at St. Michael's Hospital, and within an hour we had the patient's abdomen open. Gauze was packed around the appendix, and the swollen, gangrenous organ lifted up. Just as it reached the level of the skin it burst, and the grumous pus fell on the protecting gauze instead of dropping into the peritoneal cavity. The patient's life was saved.

When the public is educated by the profession to the necessity of early surgical interference the death rate from appendicitis will be materially reduced. To hear the argument that a certain doctor has treated so many cases medicinally, and that they have all recovered, simply shows that he has had but slight experience. Surely such an argument is offset by one that I might use, that I have operated on a large number of cases in the interval between the attacks and that they have all recovered.

I would like to learn what medicinal treatment is in these cases? On what principle it is based? how the medicines act? and what they do? I am a great believer in the production of adhesions, in the sending forward to the front of armies of leucocytes to work their way into the enemy's country, in the protective properties of the omentum, but I am not much of a believer in the action of any medicines yet known on the poisonous toxines produced by peritonitis.

Now for a word regarding the second stage of the disease. The public have begun to call it, "The too late stage"—the stage of neglect and inactivity on the part of the physicians. The question is constantly asked the surgeon, "If my son or daughter had been operated on sooner, might not his or her life have been saved?" The surgeon, to protect his professional brother, says nothing to incriminate him, but does not tell, perhaps, the whole truth.

Every third year student should be able to diagnose a case of appendicitis. The literature of the present day is teeming with cases, and members of medical societies are sick and tired of discussions of the subject.

It is too late to call a surgeon to operate on a case after the pulse has become rapid, rupture (the so-called secondary rupture) has taken place, and the whole peritoneum has become inflamed. This is not the period for operation, the golden opportunity has slipped by. It is owing to the fact that so many operations have been done in this stage that surgical treatment of appendicitis has been somewhat discredited. Such cases do recover with a long convalescence, and after hovering on the grave for days, but no such prolonged convalesence is noticed in cases operated on within twenty-four hours of the onset of the attack. These cases invariably do well if operated on by a skilled surgeon and with proper precautions.

The essayist concluded by saying that it was possible, by careful consideration of the symptoms, to make a positive diagnosis of appendicitis in its earliest stage, that it is much easier to lift the abdominal veil to ascertain the condition present and remove the source of danger. If exploratory operation is ever justifiable, when the symptoms of appendicitis are present it is doubly so.

Dr. F. Oakley asked how the diagnosis was made in the second case where the pain was on the right side.

Dr. A. A. Macdonald agreed with the essayist in regard to early operative treatment. Delay was dangerous. The so-called recovery in non-operative cases was not a permanent recovery. Referring to rupture following operation, Dr. Macdonald said it was not always easy to cure. Patients did not like to submit to another operation.

Dr. Wm. Oldright said that in his experience the point of tenderness was not always where the mischief was. He thought cases of rupture would be lessened in number if the same pains were taken to close the abdominal incision as is afterwards taken to close the hernial opening. He was in favor of the layer by layer method of closing rather than by the *en masse*.

Dr. W. J. Wilson asked Dr. Ross if he could formulate any rules as to when the operation was necessary. Would he operate after the first attack invariable? In the early days of his practice, Dr. Wilson said, the term inflammation of the bowels was a common one, and used to inspire terror into the people, so that for any sudden abdominal pain at night the doctor was sent for. But people had got over the scare and night work had dropped off one-half. Now, all these cases were being handed over to the surgeon.

Dr. McKeown spoke of his case, which Dr. Ross had referred to in the paper. He (Dr. McKeown) did not think operation in that case was necessary. The patient was vomiting and had a good deal of pain, but there was not much elevation of temperature nor was the pulse much faster than normal, yet on opening the abdomen a gangrenous appendix was found.

Dr. Carveth spoke of the difficulty of making a diagnosis between appendicitis and disease on the right side of the pelvis.

Dr. H. H. Oldright discussed the differential diagnosis between appendicitis and typhlitis.

Dr. Webster reported a case of sudden abdominal pain where he advised against operation, but two weeks after the patient consulted another man and operation was done, the appendix being removed. The patient still complained of the same pain.

Dr. J. N. E. Brown asked the essayist in how many cases of recurrent appendicitis had he noted, on removing the appendix, that there had been primary rupture.

Dr. Harold Parsons referred to the differential diagnosis of appendicitis from biliary colic and supuration in the gall-bladder. This point had been strongly brought to his mind at Johns Hopkins Hospital. He was called suddenly to see a nurse who gave a history of

repeated attacks of pain on the right side of the abdomen on going to work. There was a good deal of pain, marked rigidity on the right side, tenderness and vomiting. This he thought was appendicitis, as did Osler and others who saw it. On opening up, an intense degree of infection of the gall-bladder and gall-stones were found, with adhesions all about, matting the omentum and intestines.

There was another case of interest: A patient came into the hospital with painful micturition and marked tenesmus. On opening, an appendiceal abscess was found behind the bladder.

In another case great pain was noted over the region of the liver. A long gangrenous appendix was found with an abscess formation on top of the liver. Another point Dr. Parsons called attention to was the fact that pressure over one side would produce pain on the other, especially where adhesions were extensive.

Dr. MacMahon said that he had found a large number of cases go along well without operation. His first twenty-two recovered without a death. His practice was to call in an abdominal surgeon, with a view to operation if that was considered necessary. There was a good deal of difficulty in persuading patients with the milder types of the disease to undergo operation.

Dr. F. N. G. Starr agreed with Dr. Oldright that the pain was referred in the early stage to the region over the central nerve trunks, consequently about the umblicus. After the inflammation has lasted some time the pain becomes localized over the organs affected. As to the advisability of operating in the early stage he was not prepared to go "the whole hog," owing to the fact that so many got over the first attack without operation and do not have recurrence.

Dr. Dickson referred to a case which had gone the rounds, having been treated for nervous dyspepsia. Finally one surgeon guessed at appendicitis and operated, finding a thickened appendix.

Dr. Ross replying, said that the patient in the second case which Dr. Oakley had inquired about, gave a history of a previous well-marked attack. Besides, a mass could be felt on the right side of the abdomen. He agreed that during the first few hours of an attack the pain was over the whole abdomen, but later it became localized. He favored the *en masse* suture in closing the abdominal incision. He had come to believe in operating as soon as the diagnosis was made. The cardinal symptoms were sudden pain in the abdomen, vomiting, tenderness on pressure, and rigidity of the right abdominal muscles. One never knew when recurrence would take place. It might be ten, twelve, fifteen or more years after. In the diagnosis between this and disease of the right Fallopian tube it was to be

remembered that the latter condition was rare apart from disease on the other side.

He thought the case reported by Dr. Dickson was neurotic. In reply to Dr. Brown's question, he said in nearly every case of operation in recurrent cases there was a scar showing sign of primary rupture having taken place at some earlier date. He thought biliary colic was not often taken for appendicitis; at any rate a section was called for. He believed Dr. MacMahon would soon change his view on the question of operation.

Dr. G. Gordon reported a case. He had seen the patient eight years ago. The symptoms were those of flatulent dyspepsia. Later, neuralgia supervened over one eye, with muscular twitchings in the hands. Two years after the hands became numb. There was extreme headache; there was also vomiting after taking food. He had slight attacks of dizziness. Treatment was directed to the liver, stomach and bowels, still the symptoms persisted, the headache becoming very intense. The eyes showed well-marked optic neuritis. The signs were those of cerebral tumor. Under large doses of the iodide of potash the symptoms almost disappeared, but only to return after some months. The patient then went abroad for a time with benefit, but he soon relapsed into a worse condition than before. The arteries were always extremely hard; there was no albuminuria. Later, aphasia became marked, but disappeared during the last six months of life. The patient became very irritable and hard to manage. He death occurred about a month ago. Dr. H. B. Anderson did the post-mortem. There was very marked atheroma of the arteries. Miliary aneurisms were universally found. All through the brain there were found areas of focal softening.

This case was briefly discussed by Drs. Parsons, Wilson and MacMahon.

J. N. E. Brown,
Recording Secretary.

The American Medical Association.

Section on Materia Medica and Therapeutics.

The following papers and discussions have been promised for the meeting at Denver, Col., June 7-10, 1898:

"Yellow Fever: Its Etiology and Treatment." Discussion by Surgeon-General George M. Sternberg, M.D., of Washington, D.C; Prof. John Guitéras, M.D., of Philadelphia, and others.

"Aims of Modern Treatment of Tuberculosis." By Prof. Edwin Klebs, M.D., of Chicago.

"Serum-therapy of Tuberculosis." By Prof. S. O. L. Potter, M.D., of San Francisco, Cal.

"The Therapeutics of Pulmonary Phthisis." By Paul Paquin, M.D., of St. Louis, Mo.

"The Practical Value of Artificial Serum in Medical Cases." By P. C. Remondino, M.D., of San Diego, Cal.

"The Present Status of Serum-therapy." By George W. Cox, M.D., of Chicago, Ill.

"Biological Activity of the Antitoxins." By Prof. Joseph McFarland, M.D., of Philadelphia, Pa.

"Glandular Extracts." By Prof. Isaac Ott, M.D., of Easton, Pa.

"The Use of Remedies in Diseases of the Heart and Blood-vessels." By T. Lauder Brunton, M.D., D.Sc., F.R.S., of London.

"The Mescal Button." By Prof. D. W. Prentiss, M.D., of Washington, D.C., and F. P. Morgan, M.D.

"The Modern Intestinal Antiseptics and Astringents." By William Frankhauser, M.D., of New York.

"A New Non-amylaceous Flour for Diabetics and Dyspeptics." By N. S. Davis, Jr., A.M., M.D., LL.D., of Chicago, Ill.

"The Solution of Ethyl Nitrite." By D. J. Leech, M.D., of Manchester, Eng.

"A Contribution to the Effects of Coffee in Excess." By Prof. William Pepper, M.D., LL.D., of Philadelphia, Pa.

"The Treatment of Insomnia." By Robert T. Edes., M.D., of Jamaica Plain, Mass.

"Are there Therapeutic Principles?" By Solomon Solis-Cohen, M.D., of Philadelphia, Pa.

"To What Extent is Typhoid Fever Favorably Modified in Its Course, Duration, Termination of Sequelæ by the Administration of Drugs." By Frank Woodbury, M.D., of Philadelphia, Pa.

"Strychnine." By J. N. Upshur, M.D., of Richmond, Va. Discussion by Prof. J. H. Musser, M.D., of Philadelphia, Pa.; Walter M. Pyle, A.M., M.D., of Philadelphia, Pa.

"Methods of Teaching Materica Medica and Therapeutics." By Prof. G. H. Rohé, M.D., of Baltimore, Md.

"The Study of Materia Medica and Therapeutics." By H. M. Bracken, M.D., of Minneapolis Minn.

"A Contribution to the Pharmacology of Cannabis Indica." By C. R. Marshall, M.A., M.B., Pharmacological Laboratory, Downing College, Cambridge, England.

"The Place of Hydrochloric Acid in the Treatment of Diseases of the Stomach." By Boardman Reed, M.D., of Philadelphia, Pa.

"The Continuous Use of Digitaline in the Vasomotor and Cardiac Lesions of Senility." By Henry Beates., Jr., M.D., of Philadelphia, Pa.

"Home Remedies *versus* Patent Medicines." By Prof. Adolph Koenig, M.D., of Pittsburg, Pa.

"Opium in Bacterial Diseases." By J. P. Farnesworth, M.D., of Clinton, Ia.

"The Great Therapeutic Importance of a Rational Adaptation of Cathartic Remedies to the Physiological Functions of the Gastro-intestinal System." By E. D. McDaniels, M.D., LL.D., of Mobile, Ala. Discussion by Professor John M. Dunham, A.M., M.D., of Columbus, O.

"A Recognition of Temperament: a Factor to the Selection of Remedies, and their Dosage in Disease." By J. E. Moses, M. D., of Kansas City, Mo.

"On Some Preparations of the National Formulary." By C. Lewis Diehl, Ph.G., of Louisville, Ky.

"The Use of Stimulants in Acute Diseases." By E. B. Hershey, M.D., of Denver, Col.

"Codeina" By A. K. Minich, M.D., of Philadelphia, Pa.

"Therapeutics of Idiopathic Epilepsy." By Prof. J. N. Barnhill, A.M., M.D., of Columbus, O.

"The Use of Drugs in Diseases of the Uterus." By Prof. John M. Dunham, A.M., M.D., of Columbus, O.

"Why the Pharmacopœial Preparations should be Prescribed and Used by the Profession." By Leon L. Solomon, M.D., of Louisville, Ky.

"The Use of Electricity by the General Practitioner." By Caleb Brown, M.D., of Sac City, Ia.

"The Relation of Pharmacal Legislation to Pharmacal Education." By Willis G. Gregory, Ph.G., of Buffalo, N.Y.

"The Uric-Acid Diathesis: Its Cause and Maladies Resulting from it. Is it a Cause or an Effect of Bright's Disease of the Kidneys?" By H. V. Sweringen, M.D., of Fort Wayne, Ind.

"The Sulphocarbolates." By Prof. William F. Waugh, M.D., of Chicago, Ill."

"Incompatibles." By E. A. Ruddiman, Ph.M., M.D., of Nashville, Tenn.

Fraudulent Claims—The Remedy." By C. C. Fite, M.D., of New York.

"The Selection of Diuretics and Lithontriptics in Diseases of the Urinary Tract." By Ernest L. Stephens, M.D., of Fort Worth, Texas.

"Life-history of the Bacillus Tuberculosis in its Relation to the Treatment by Tuberculin." By Robert Reyburn, M.D., of Washington, D.C.

"The Chemistry of the Albuminates." By F. E. Stewart, M.D., of New York.

The chairman will be pleased to receive and place upon the programme subjects for discussion and papers. John V. Shoemaker, M.D., chairman, 1519 Walnut St., Philadelphia, Pa.

Ratio of Physicians to Population.—The statistical data bearing upon the ratio between physicians and the general population of Germany, as given out in the new edition of the "Deutsche Medicinal-Kalender," are interesting. We learn that there were 24,873 physicians in the empire during the year 1897; a ratio of 4.5 physicians to 10,000 inhabitants. In 1883 the ratio was 3.33 to 10,000; in 1890 it was 4 to 10,000. Thus 1897 shows a decided increase. Berlin, with its 1,750,000 inhabitants has 2,196 physicians, or 1 to 800. Ten years ago there was but 1 physician to 1,218 inhabitants. This is an increase of almost eighty per cent. In the meantime the population increased but nine per cent. Throughout the entire empire there exists a similar disproportion. When we furthermore learn that during the first years of the last decade there was a slight falling-off in the number of medical students, which, however, has since been surely and steadily increasing, we cannot but conclude that there is a most unwholesome over-production of physicians. France has from 26,000 to 27,000 physicians; Paris, with its 2,500,000 inhabitants, 2,500, or 1 physician to 1,000. England, on the other hand, has but 20,000.—*Berlin correspondent Medical Record.*

Editorials.

The Victorian Order of Nurses.

We learn that this order has opened a branch for Toronto, with headquarters at 206 Spadina Avenue.

It has pleased the Committee of Management to select as the lady superintendent of the Toronto branch a nurse who received her training in Bellevue hospital. We are of the opinion it would have met with more favor to have selected someone who had been trained in a Canadian hospital, and would have been more in keeping with good taste and popular sentiment, especially as it is the Canadian people, and not the Americans, that are being appealed to for the requisite funds for this so-called crusade against disease.

It was announced at the opening of the Toronto branch that nurses could be had at any hour, night or day, for a fee ranging from 5 cents to 50 cents per visit. It will thus be seen that the very thing the Medical Review has frequently pointed out, has already taken place. These nurses are placed in direct competition with our trained and efficient nurses for a living. It is true that these nurses are paid a salary, and that these fees go into the general funds of the order. But this is a matter over which those who wish to obtain a nurse at cheap prices, will not concern themselves. So long as they can obtain a nurse at such rates, there will be but poor chance for these who seek to make a living in the ordinary way. It is only too true that many persons who could pay a proper fee for a nurse will avail themselves of these cheap rates.

While dealing with this question, we would mention that Dr. J. Spence, who spoke so strongly against the Victorian Order of Nurses when advocating his claims for election to the Medical Council before a recent meeting of the West Toronto Territorial Association, was awarded the honor of sending in the first call to the Victorian Home.

We extract the following from an editorial in the last issue of the *Montreal Medical Journal* bearing on this Order :

"We candidly confess, however, that we cannot but regret that it should have been thought wise by the central authorities to issue an appeal for funds to send nurses to the Klondike. Were those who are now rushing northwards impelled by noble desire, were their object to add to the glory to our Dominion rather than fill their own pockets, there would be strong reason for asking for this fund for nurses ; as it is,

it is difficult to manufacture sympathy for the run after gold. We do not mean to say that it is not right that there should be nurses, and good nurses, in the Klondike, or that we are insensible to the hardships which will be undergone in the far north ; we only say this, that, as a matter of policy, the appeal, coming at the present time, is a mistaken one. It is but another proposal by which it will be impossible to arouse enthusiasm for the Victorian Order."

Qualifications to Practise in the Yukon.

PHYSICIANS desirous of legally practising in the Klondike region may do so (1) if they hold British qualification and pay a registration fee of $50.00; (2) not having such qualifications, they must pass an examination and pay the same fee. Dr. H. N. Bain, Prince Albert, N.W.T., is the Registrar of the Territories. The authorities are insisting on the strict carrying out of these regulations. This is right. The examinations are similar in character to those in British Columbia, the subjects of which and the British Columbia regulations we append :

SECTION 1. Section 29, of the Consolidated Statutes of British Columbia provides : "The Council shall admit upon the register any person who shall produce from any college or school of medicine or surgery, requiring a three years' course of study, a diploma of qualification ; provided, also, that the applicant shall furnish to the Council satisfactory evidence of identification, and pass before the members thereof, or such of them as may be appointed for the purpose, a satisfactory examination touching his fitness and capacity to practise as a physician and surgeon." 1886, C. 13, S. 28. * * *

"SECTION 3. Every person applying for registration under Section 2 of the 'Medical Act, Amendment Act, 1893,' shall, on appearing in person before the Registrar of the Council, and paying a fee to the Registrar of $100.00, be entitled to be registered, on producing to such Registrar a certificate duly authenticated under the hand and seal of the Registrar of Medical Practitioners in England, Ireland and Scotland, as the case may be (or other legal evidence), that such applicant is a duly registered medical practitioner, and that he was duly registered under the 'Medical Act' (Imperial) on or before the 30th day of June, 1887. Such applicant will also be required to produce a certificate of good standing in the profession of medicine from the Registrar or other officer of the medical body having jurisdiction where such applicant last practised his profession, and

evidence by statutory declaration that he has not lost the benefit of his said registration under the 'Medical Act' (Imperial) by misconduct or otherwise. * * *

"SECTION 4. The examination shall be orally and in writing, upon the following subjects: (1) Anatomy, (2) Chemistry, (3) Physiology, (4) Pathology, (5) Materia Medica, (6) Medical Jurisprudence, (7) Theory and Practice of Medicine, (8) Surgery, (9) Clinical Medicine, (10) Clinical Surgery, (11) Obstetrics, and Diseases of Women and Children. Marks required: 50 per cent. in first six branches, 75 per cent. in others. * * *

"SECTION 7. During the year there shall be three regular meetings, and three examinations held, beginning on the first Tuesday of May and September, and the second Tuesday of January, in Victoria, B.C. * * *

"SECTION 8. Permits are not granted by the Council."

Powers Needed by the Medical Council.

THE Act applying to the Medical Council ought to be enlarged in some directions. There are a certain number of persons who conduct a medical practice who have no legal right to do so. They manage, however, to escape the law, as it now stands, by selling some proprietary medicine. They do not actually charge for their advice, but they do for the medicine they supply to the patients. Thus, under the guise of selling a secret nostrum they carry on an active practice in reality. The Council should have power to deal with such quack practitioners.

Then, again, there is another class of practitioners that comes from time to time, usually from Paris, or from the British army, or from Dublin, or from anywhere that their fancy may lead them think would give them some notoriety. These men pretend to be scientific to the highest degree. They are appearing in the columns of the press through the medium of paid interviews, or in some glaring advertisement, looking down some one's throat, or into his eye, or at a crooked bone by the X rays. These medical vultures, cormorants, things, are a disgrace to the list of practitioners on the register of the College of Physicians and Surgeons. The Council should have power to remove from the register the name of any person who conducts his practice in this bad and unseemly manner.

There is another serpent in the fold—those who sell themselves to quacks who from time to time visit this country. These are the

persons that give the operations of these quacks an air of legality. Can one think of anything more disgraceful than a qualified practitioner lending himself to some shark who peregrinates through the country, telling the most scandalous lies as to the cures he can perform and robbing the unwary! Down with this thing; it is positively criminal.

The International Association of Railway Surgeons.

THE meeting will be held in Toronto on Wednesday, Thursday and Friday, July 6th, 7th and 8th, 1898. These dates have been decided on, so as not to interfere with other important medical meetings in United States and Canada; also, because the weather will be very warm in the country to the south of us about that time, so we expect a large number of members to come north and enjoy with us the cool breezes of Lake Ontario.

This will be the eleventh annual meeting, and it is the first time the Convention has been held outside the borders of the United States. Other places where meetings have been held are: Chicago, Detroit, St. Louis, Omaha, Galveston and Old Point Comfort, Va.

The purposes of the Association is stated in Article 1, Sec. 2 of the Constitution, viz.:

"The object of the Association shall be to promote acquaintance and fraternal relations among railway surgeons, to secure interchange of ideas, and the adoption of the best methods of development and improvement of railway surgery, and to establish it as a special branch of the chirurgical art."

At present, there are about six hundred members paid up for this year, but many join at each meeting; as an instance, at Galveston we had between eleven and twelve hundred present. Canadian railway surgeons have not been very numerous at the meetings of the Association heretofore, about forty being the largest number during any year; but we expect to have the support of all Canadian surgeons connected with the various railway systems of this country at this the first Canadian meeting. We expect to have representatives from all important railway centres, from Halifax to Vancouver.

Free transportation will be granted to members of the Association connected with railways to and from Toronto upon application through the proper officers of the company employing such surgeons. C. M. Hays, Esq., General Manager of the Grand Trunk Railway system, has kindly signified his desire to give an excursion to the

members attending the Association meetings, from Toronto to the Muskoka Lake district. This excursion will probably take place on Saturday, the day following the closing of the meeting.

Other entertainments of a social nature are being arranged for.

The Chairman of Committee of Arrangements would be pleased to hear from any Canadian railway surgeon who would favor the meeting with a paper.

Application blanks for membership will be forwarded by the Treasurer of the Association, E. R. Lewis, Kansas City, Mo.

The President suggested the subject of "Shock" for the special consideration of the coming meeting. Different aspects of the subject will be presented by members already chosen by the President.

A daily journal, the *Railway Surgeon*, will be published during the meetings.

An exhibition of surgical appliances and physicians' supplies generally will be a feature; at Chicago last year thirty-nine manufacturers had exhibits, some firms having four or five representatives present to show their goods. The duty being now removed from surgical instruments should insure a large show of these goods by foreign manufacturers.

The Executive Board of the Association includes: J. B. Murphy, of Chicago (who introduced Murphy's button); J. N. Jackson, Kansas City; W. B. Outten, St. Louis; J. A. Duncan, Toledo; J. H. Letcher, Henderson, Kentucky; A. I. Bouffleur, Chicago; Frank Lutz, St. Louis.

The local Committee of Arrangements is in course of formation.

Officers for 1897-8: President, Surg. Geo. Ross, Richmond, Va.; Vice-presidents, Surg. J. A. Hutchison, Montreal, Can.; Surg. A. L. Fulton, Kansas City, Mo.; Surg. De Saussure Ford, Augusta, Ga.; Surg. John J. Buchanan, Pittsburg, Pa.; Surg. H. L. Getz., Marshalltown, Ia.; Surg. R. R. Lawrence, Hartford Mich.; Surg. W. Q. Marsh, Sierra Mojada, Mexico; Secretary, Surg. Louis J. Mitchell, Chicago, Ill.; Treasurer, Surg. Eugene R. Lewis, Kansas City, Mo.; Executive Board, Surg., A. I. Bouffleur, Chairman, Chicago, Ill.; Committee on Transportatfon, W. B. Outten, Chairman, St. Lous, Mo.; Local Committee of Arrangements, Surg. B. L. Riordan, Chairman, Toronto, Canada.

Dr. William S. Playfair has resigned from the chair of obstetrics and diseases of women at King's College, London, which he has filled for twenty-five years.

HONOR TO WHOM HONOR IS DUE.—The Chapter of the Order of the Hospital of St. John of Jerusalem in England, with the sanction and approval of Her Majesty the Queen, has appointed as honorary associates, or members, of the 4th class of the order, the following: Hon. W. F. Borden, Minister of Militia; Dr. T. R. Roddick, M.P., President of the British Medical Association, and Major John Bayne Maclean, President of the Canadian Press Association. The Chapter has passed a special vote of thanks, and ordered it to be engrossed on vellum, to Dr. C. R. Dickson, local secretary of the St. John Ambulance Association in Toronto. These distinctions are conferred for services in connection with the St. John Ambulance Association, the President of which is H.R.H. the Prince of Wales.

AN OFFICIAL PRONOUNCEMENT.—The Bacteriologist of the Ontario Board of Health gives the result of a searching test of Antitoxin purchased on the open market. Under date of February 1st, Mr. John Mackenzie, Official Bacteriologist of the Ontario Board of Health, reports the following results of his action in subjecting Antitoxin purchased on the open market to bacteriological tests: "I beg to report to you upon the result of a test which has been made during the past month upon Messrs. Parke, Davis & Co.'s Antitoxin. This firm has repeatedly requested that such a test should be made, but routine work in the Laboratory has been so great that it has been impossible to get the time until recently for its completion. The sample tested was bought in the open market, at a drug store, and the test applied was one to determine if the sample contained the number of antitoxic units indicated by the label. The label claimed that the bottle contained, 1,000 units, the result of the test showed that it contained over 1,200 and under 1,500 units, probably nearer 1,500 than 1,200 units. This shows that the Antitoxin was reliable, as it is necessary to place in the bottle a good margin of units in excess of the label strength, so that the loss of units which takes place by keeping may not be so great as to bring it, in a reasonable time, below the amount indicated by the label. Antitoxins differ from other drugs in this respect, that there is no danger in overdosing; the danger is rather the other way, and the rate of decrease in strength due to keeping, is determined by factors which are largely not controlled by the manufacturer."

THE TREATMENT OF EMPYEMA.—The following is a summary of the treatment as laid down by Dr. B. F. Curtis, in the *Medical Record*, March 19: While it is true that the practice of surgeons still differ

somewhat on the surgical treatment of empyema, still there is a large measure of unanimity as to what may be considered the best methods. It is still the custom with some to treat this disease by repeated aspirations. This does effect a cure in some cases. It cannot, however, be regarded as good surgery. The effect of such a plan is often to give rise to many complications, and is often very tedious. But the most important feature of this method is that it not rarely fails, often subjecting the patient to no small amount of suffering and delay. Then incision between the ribs and the introduction of a drainage tube of some kind, is a plan of treatment that has its advocates. This method is attended by some serious drawbacks, such as the experience that patients so treated usually improve very slowly, and the other that there is often left a suppurating cavity and sinus, calling for subsequent treatment. It is now generally conceded that the pleural cavity should be opened freely if it contains pus. To do this, portions of one or more ribs are removed, of sufficient extent to lay open the abscess cavity. The pleura is slit open, and in most cases should be cut away. Each intercostal artery is tied as it is divided. A layer of iodoform gauze is spread over the cavity. Dry sterilized gauze is then packed into the cavity over this layer of iodoform gauze. The skin is replaced and held in position by a few sutures. These may be loosened at each dressing to permit of easy access to the cavity. The dressings remain until either a rise of temperature or free discharge calls for their change.

Chronic Conjunctivitis.—For the least severe cases Mr. Berry recommends, in the Edinburgh *Medical Journal*, the following prescriptions for local use :

℞ Hazelini, 4 ounces.
Aquæ carui, 8 ounces.

℞ Acidi tannici, 6 or 12 grains.
Sodæ biboratis, 3 drachms.
Glycerini, 6 drachms.
Aquæ camphoræ, q. s. ad 12 ounces.

℞ Tincturæ myrrhæ, 2 drachms.
Aquæ destillatæ, 12 ounces.

℞ Aluminis, 10 to 20 grains.
Aquæ rosæ, 12 ounces.

℞ Extracti cinchonæ flavæ liquidi, 48 minims.
Acidi hydrocyanici diluti, 15 minims.
Glycerini, 6 drachms.
Aquæ destillatæ, q. s. ad 12 ounces.

—*Therapeutic Gazette.*

Correspondence.

The Editors are not responsible for any views expressed by correspondents.

To the Editor of the CANADIAN MEDICAL REVIEW:

SIR,—Dr. Graham, as champion of the Colleges and Medical Council, replies to my letter of Feb. 2nd, and evading the larger, broader question, selects a point or two, misconstrues, and makes the question a personal one only. I distinctly stated that I did not expect all to see in the same light as I did, but the ideas were my own, and I presented them to the profession for such consideration as they choose to give them. Dr. Graham says: "These examiners—I am now speaking of the Ontario Board—do not get together and fill their individual pockets from the fees of the newcomers." Now, sir, this is altogether gratuitous of Dr. Graham. I did not so imply, but it did apply to Provincial Boards, where there were no teaching colleges. Who will question my words with regard to them, or the influences that draw them together? Surely not Dr. Graham! I accuse the colleges of questionable and unquestionable ways seeking students. Is not the truth here irrefutable? Does Dr. Graham attempt justification? Dr. Graham admits that the *personnel* of the Board of Examiners is merely a matter of opinion. He begs the question of interprovincial registration, well knowing that there is no actual advance, nor is there likely to be any, on present lines. Dr. Graham does not question my remarks *re* morality of special practice. As for instance: "Special attention given to midwifery and diseases of women." He does not excuse the fingering of little girls and old girls, too, and indiscriminate treatment for fancied womb disease; he does not question the demand for printing on outside wrappers the ingredients composing patent and proprietary medicines, but he does, as a postscript, quote from the *New York Medical Journal*, and takes upon himself to assure "the *Journal* and its readers that the picture is entirely overdrawn, and that the only gloomy view to medicine here is the overcrowding of the profession." I would say, in conclusion, that if any correction to my words is needed for the New York or any other medical journal, I am quite competent to give them myself, and if Dr. Graham has any views—if they are not in agreement with mine—he is at liberty to ventilate them entirely on his own account. I close by referring Dr. Graham to my concluding sentence in your February number, on which I am prepared to stand.

Yours truly, P. PALMER BURROWS.

Lindsay, March 22nd, 1898.

Book Notices.

A Manual of Medical Treatment, or Clinical Therapeutics. By J. Burney Yeo, M.D., F.R.C.P. London: Cassell & Co. Toronto: The Publishers' Syndicate, 88-90 Yonge Street.

These two tidy volumes are well known and familiar to many. They should be familiar to all. It says much for any work that it runs through edition after edition with the rapidity of this one, especially when one considers the many excellent works on therapeutics. It would only be using a proper term to say that these volumes are a veritable store-house of information. The advice on treatment is a full reflex of the best methods of treatment at present in vogue in that great centre of medical thought—London, England. To give an example of the plan, under the heading of Blood Diseases we have Leukæmia, Hodgin's disease, Addison's disease, Graves' disease, Myxœdema fully discussed. It is really a pleasure to read the work. There is none of the dry dust about it.

Maternal Syphilis, Including the Presence and Recognition of Syphilitic Pelvic Disease in Women. By John A. Shaw McKenzie, M.D. Lond. London: J. & A. Churchill, 7 Great Marlborough Street. Price 10s. 6d.

This is an extremely difficult work to review in a short space. There is so much that is valuable and interesting that it would be quite impossible to touch upon the contents of the work. The author has exhausted the subject fully from the standpoint of the literature upon the subject. In addition to a thorough review of what has been written upon maternal syphilis, the author has something to contribute from his own experience. The author clearly has both qualifications—reading and experience—in a very marked degree. The light thrown upon the whole question from the author's own experience is undoubtedly the most attractive feature of the work. Tuberculosis and syphilis play such an important *role* in medicine and surgery that every practitioner should keep himself abreast of the times upon these diseases. We advise all to study the above work. It is a valuable contribution.

Selections.

Pelvic Congestion and Constipation.—

℞ Magnesia sulphate ..... ℥j
Iron sulphate ..... grs. xx
Manganese sulphate ..... grs. xx
Dilute sulphuric acid ..... ℥iij
Aquæ ..... ℥iv

M. Sig.—A tablespoonful in a wineglassful of water before breakfast.—*Med. News.*

A Mixture for Epilepsy.—The February number of *Pediatrics* gives the following:

℞ Sodium bromide ..... 60 parts;
Sodium bicarbonate ..... 75 "
Tincture of physostigma ..... 25 to 50 "
Water ..... 500 "
Saccharin ..... 1 part.

M. Dose, a tablespoonful, diluted with water, morning and evening; after four days, suspend its use for three days and then begin again.

An Ointment for Acute Articular Rheumatism.—Lemoine (*Nord Médical; Tribune Médicale*, February 9th) gives the following among other formulæ:

℞ Vaseline ..... 25 parts;
Salicylic acid ..... 4 "
Sodium salicylate ..... 3 "
Extract of belladonna ..... 1 part.

M. To be applied and covered with cotton.—*N. Y. Med. Jour.*

A Resolvent Mixture.—The *Gazette hebdomadaire de médecine et de chirurgie* for February 27th, gives the following formula:

℞ Ammonium chloride, Tincture of arnica } each ..... 10 parts;
Camphorated vinegar, Camphorated brandy, } each ..... 75 "
Infusion of rue ..... 300 "

M. S.: For external use.—*N. Y. Med. Journal.*

A Local Anæsthetic for Extraction of Teeth.—

℞ Menthol ..... grs. 160
Tinct. myrrh ..... drops 80
Alcohol ..... ℥ ij.

M. Sig.—Thoroughly dry the gums and apply freely for a few minutes. Use more freely for a permanent than a deciduous tooth.—*Pediatrics.*

Pruritus of the Genital Organs.—*Scrotal.*—Professor Brocq recommends the following solution for pruritus of the scrotum:

Phenic acid ..... ℥v.
Glycerine ..... ℥iijss.
Proof spirit ..... ℥vi.
Water ..... ℥x.

From one to four tablespoonfuls in a glass of hot water to bathe the parts three or four times a day, and twice a day a wafer containing sulphate of quinine and bicarbonate of soda is swallowed. In pruritus of the vulva, Professor Tarnier prescribes:

Bichloride of mercury ..... grs. x.
Alcohol ..... ℥ss.
Rose water ..... ℥v.

After washing the region with soap and tepid water the patient passes rapidly a plug of cotton wadding, steeped in the solution, over the seat of the itching. The first sensation is that of burning, but this is quickly relieved by applications of cold water. The subsequent lotions become less and less painful, and the cure is generally rapid. —*Med. Press.*

A New Staining Method for Sections of the Skin.—By Dr. Mamarowsky (*Monatshft. f. Prakt. Derm.*). The portions of skin are placed for 24 hours in a saturated solution of sublimate, containing 5 per cent. bichromate of potash and 0.6 per cent. sodium chloride. Sections are cut in paraffin. The sections are stained for 15 minutes in slightly heated picrocarmine, washed in water and then stained 30 minutes in alum hæmatoxylin. The sections are next stained 1½ minutes in a saturated solution of acid picronitr., until the dark-red epidermis can be distinguished from the light rose-colored corium. Wash in water, dehydrate, clear and mount. The horny layer and blood are stained yellow, smooth muscle structure gold-yellow, the small celled infiltration dark violet, the rete Malpighi violet. The staining is very permanent.—*The Post-Graduate.*

Constipation in Babies.—For constipation occurring in babies during the first year, and not relieved by regulation of the diet, Carron de la Carrière recommends light massage of the abdomen with the palm of the hand well oiled. The movement should be made in a circle about umbilicus, pressure being light, and exerted especially in the right iliac region. Each sitting should occupy not more than ten minutes, and should take place in the morning. For babies after the first year, massage may be made with the finger-tips over the course of the large intestine from the right to left.—*Practitioner.*

Artificial Oysters.—The municipal authorities of Paris are just now engaged in the suppression of an altogether novel form of food adulteration, which is assuming phenomenal proportions, according to the New York *Tribune*. Real oysters are expensive in Paris ; and so, with the object of suiting slender purses, artificial oysters on the half-shell have been invented, which are sold at twenty cents a dozen, and they are so cleverly made, and look so nice and fresh, that, once lemon juice or vinegar has been added, they cannot be distinguished from the real article, especially when white wine is taken in connection therewith. The only genuine thing about these oysters is the shell, the manufacturers buying second-hand shells at a small cost, and fastening the spurious oyster in place with a tasteless paste. The municipal laboratory has not yet proclaimed the ingredients of which these bogus oysters are composed, but has announced that they are of a harmful character.—*Boston Medical and Surgical Jour.*

The Significance of Casts and Albuminuria.—At a recent discussion in New York Academy of Medicine on albuminuria, Dr. William Henry Porter asserted that hyaline casts were not uncommonly found in the urine of persons who were in the habit of eating too much, and in whom there was a tendency to the over-production of uric acid. Under such circumstance the presence of hyaline casts in the urine meant little more than that an isomeric albumin had been excreted through the renal cells and had been precipitated by the uric acid. If however, there was also epithelial or nucleated casts, there was good reason to believe that the kidneys were positively diseased. The same observer bases his prognosis, in cases of albuminuria, largely on the habits and methods of eating of the individual. Thus, if the person is an animal-feeder, he is inclined to give a favorable prognosis, but if the patient is largely a vegetarian, or indulges freely in fruits, his experience leads him to give a much graver prognosis.—*Phil. Med. Jour.*

Treatment of Mania.—By Magnan (*Revue de Psychiatrie*). The author's advice regarding the treatment of mania is summarized as follows: 1. No restraint and rest in bed. The patient should never be put in a cell except as an absolutely last resource. 2. Baths, bromide and chloral. 3. When there is intense excitement and profound insomnia, hydrochlorate of hyoscine may be used subcutaneously. 4. The most concentrated nutrition must be given, frequently repeated, and all forms of fermented liquors interdicted. The straight jacket is never used. To quiet the patient, baths at 33° C. are given, the patient being kept in the water for from two to five hours, and at the same time cold applications are made to the head. If the patient is extremely maniacal wet packs may be used instead of the baths. In the evening the patient should receive from 40 to 60 grains of bromide of potassium, and two or three hours later from 20 to 40 grains of chloral. After a week or so when the patient has quieted somewhat, the dose of bromide is diminished and the chloral is given only occasionally, sulfonal and trional being substituted. Patients that are rebellious to the bromide-chloral medication often take increasing doses of laudanum with very good effect. Morphine should not be given. Over-medication is the mistake usually made in the treatment of acute mania.—*The Post-Graduate.*

Treatment of Syphilis.—A. Neisser ("Die Einreibungskur," Volkmann's "klinische Vortrage," No. 199, December, 1897) considers that the results obtained in the treatment of syphilis by the inunction of blue ointment are referable, not to the comparatively small amount of the agent which actually makes its way through the skin, but to the inhalation of the vapor of mercury, which the warmth of the patient's body is constantly causing to be given off. He recommends that patients spend as much of their time as possible in a single, well-warmed room, taking as little out-door exercise as is compatible with health, in order that they may be constantly surrounded by an atmosphere charged with the volatilized metal. His routine is to apply four grams of a thirty-three-and-one-third, or fifty-per cent. ointment, either at bedtime or on rising (no friction is necessary), increasing the amount by one gram every tenth application and continuing the treatment for forty-two days. If the mouth is properly cared for by the plentiful use of astringent and antiseptic lotions, the author thinks that stomatitis and salivation should never be produced, although a mild degree of either does not in most cases require suspension of the treatment for any great length of time.—*Medical Record.*

Miscellaneous.

POLK'S MEDICAL AND SURGICAL REGISTER OF THE UNITED STATES AND CANADA is now undergoing the fifth revision, and physicians who have not given their names to the canvassers are urged to send them to headquarters at once. Address R. L. Polk & Co., Detroit, Mich.

PAIN IN OTITIS.—Dr. George H. Powers, Professor of Ophthalmology and Otology in the University of California, San Francisco, in an article in the *Medical News*, writes as follows, in reference to the treatment of pain in otitis: "At my first visit I found a copious discharge of bloody serum from the ear with hardly a trace of pus. He suffered from severe cephalalgia, but there was no special tenderness in or about the ear, and no swelling. Thorough cleansing of the meatus with dry cotton relieved the pain in the head remarkably, and with a dose of antikamnia, 10 grains, he slept some hours."

A DOG, A PIPE, AND A WOMAN.—A patient in the Royal Infirmary, for whom it was my duty to perform minor surgical services, presented me one New Year's day with a fine specimen of a Skye terrier pup as an expression of gratitude. Professor Syme happened to come suddenly and unexpectedly upon me one day while sitting on the doorstep of the Royal Infirmary after business hours, along with one or two of the old nurses, playing with my pup. In a good-natured, pleasant manner he said, "Mr. Maclean, is that your dog?" I had no choice but to plead guilty. He at once assumed an air of mock severity and looking straight at me said, "Then permit me to inform you that there are just three steps to ruin a young man: first, a *dog;* second, a *pipe;* and third, a *woman.*" The experiences of my life from that day to this have, I must say, failed to fully justify the professor's oracular utterance. I have rarely seen the day that I have not been the happy possessor of one or more dogs, and surely have had no occasion to blame them for any misfortunes which may have befallen me. As for the pipe, I have never availed myself of its comforting and insidious influences; and so far as the third, and last, "step" is concerned, I have only to declare, as a matter of actual truth and simple justice, that from my cradle to the present time women have ever been my greatest comfort, blessing and inspiration, in spite of an occasional attack of heartache which, after all, proved to be quite evanescent.—DR. MACLEAN in *Medical Age.*

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Durand, Mich.

THE LAW OF MEDICAL CONFIDENTIALITY.—In a recent number of the *Scottish Medical and Surgical Journal* Mr. A. Taylor Innes deals with this question clearly and concisely as follows: "The obligation of confidentiality on the part of the medical man in Scotland to whoever employs him has been affirmed in the most absolute way. He must decline to publish not only what is false and slanderous, but also what is true and what would be quite proper to be published by those who had learned it other than professionally. His legal obligations to secrecy, so far from being 'the same as of a non-professional man,' are expressly founded by the law on the professional contract which the law construes as existing between him and his employer. One result of this is that the obligation to secrecy covers *everything*. The medical man is not entitled to gossip about what he has learned in a professional call, even though he thinks the gossip harmless. Such gossip is equally illegal with the gravest slander, and may equally 'afford relevant ground for an action of damages,' though the *amount* of damages due in such a trivial case may be represented by a very small coin of the realm. In the case of a *non*-professional man, it may be questioned whether the obligation of confidentiality is for him a general rule at all—it may be rather an exception arising when something is expressly or exceptionally confided to him. But in the case of a medical man, it is a general rule, and indeed, a universal one. The rule is universal—that is it extends to everything so long as the medical man is acting voluntarily and of his own free will. In that—the ordinary case—nothing is to be revealed. But there is another case in which everything may have to be revealed. That other is the exceptional case, when the medical man is called to speak by competent authority and in the interest of the public—when especially, he is in the witness-box. The right to refuse to speak on such a public occasion is known as *privilege*; and rightly or wrongly, there is no privilege allowed to medical men by either the English or the Scottish law.—*N. Y. Medical Journal.*

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The Discoveries of Joseph Jackson Lister.—That Lord Lister's father was a very great man is a fact that does not seem to be generally known. He was almost as eminent in his particular branch of science as is the discoverer of antisepsis, but the fame of the father has been overshadowed by that of the son. Joseph Jackson Lister, although a man of business, found time to make perhaps the most important improvement in the microscope ever effected and to render possible the marvellous researches in bacteriology of modern times. In addition to this, he was also the first to describe the tendency of the red corpuscles of the blood to arrange themselves in rouleaux. Dr. Henry Smith Williams, in the current number of *Harper's Monthly Magazine*, referring to the older Lister, says: "To Joseph Jackson Lister is due the chief credit for directing those final steps that made the compound microscope a practical instrument instead of a scientific toy, combining mathematical knowledge with mechanical ingenuity; and, having the practical aid of the celebrated optician Tulley, he devised formulæ for the combination of lenses of crown glass with others of flint glass, so adjusted that the refractive errors of one were corrected or compensated by the other, with the result of producing lenses of hitherto unequalled powers of definition. . . . . Lister had begun his study of the lens in 1824, but it was not until 1830 that he contributed to the Royal Society the famous paper detailing his theories and experiments. Soon after this various continental opticians, who had long been working on similar lines, took the matter up, and their expositions, particularly that of Amici, introduced the improved compound telescope to the attention of microscopists everywhere.—*Medical Record.*

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